

TENOLD CHIROPRACTIC HEALTH & REHAB CLINIC

www.tenoldchiropractic.com

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NEW PATIENT INFORMATION – MINOR CHILD – BIRTH THROUGH FIVE YEARS OLD

About you...

Name: First: _____ M.I.: _____ Last: _____ Date: _____
Street _____ City _____ State _____ Zip _____
Home Phone () _____ Name of School _____
DOB: / / Age: Male/Female Student Status: full time/part time/not enrolled

Parent or Guardian information...

Father: _____ Mother: _____
SS# _____ DOB: _____ SS# _____ DOB: _____
 Check box if same address as patient Check box if same address as patient
Address: _____ Address: _____
City, State, Zip _____ City, State, Zip _____
Home/work phone _____ Home/work phone _____
Employer _____ Employer _____
Legal Guardian: yes / no _____ Legal Guardian: yes / no _____

Billing Information... (This is the person to whom the statements are sent.)

Person responsible for the account: _____
If different from patient's, what is their: 1.) address: _____
2.) phone: () _____
Insurance company: _____ Phone: () _____
Name of Insured: _____ Due to: Auto Accident Y / N School injury Y / N
Has your child had chiropractic care before? Y / N If so, when? _____
How did you hear about us? _____ Email address: _____

Pregnancy... Check any areas that apply to the mother during her pregnancy

- | | |
|--|---|
| <input type="checkbox"/> caffeine: chocolate | <input type="checkbox"/> premature contractions |
| <input type="checkbox"/> caffeine: cola | <input type="checkbox"/> recreational drugs |
| <input type="checkbox"/> caffeine: coffee | <input type="checkbox"/> excessive weight loss |
| <input type="checkbox"/> caffeine: tea | <input type="checkbox"/> excessive weight gain |
| <input type="checkbox"/> caffeine: other | <input type="checkbox"/> attitude: mostly happy |
| <input type="checkbox"/> complications | <input type="checkbox"/> attitude: mostly depressed |
| <input type="checkbox"/> medications | <input type="checkbox"/> vitamins/minerals |
| <input type="checkbox"/> smoking | <input type="checkbox"/> toxic exposures |
| <input type="checkbox"/> alcohol | <input type="checkbox"/> allergic reactions |
| <input type="checkbox"/> hospitalization | <input type="checkbox"/> chiropractic care |
| <input type="checkbox"/> bleeding | <input type="checkbox"/> physical injury |
| <input type="checkbox"/> vaccination(s) | <input type="checkbox"/> carried to full term |
| <input type="checkbox"/> back pain | <input type="checkbox"/> mental trauma |
| <input type="checkbox"/> other pain | <input type="checkbox"/> prenatal classes |
| <input type="checkbox"/> prenatal care | <input type="checkbox"/> any diagnosed illnesses |
-

Labor and Delivery...

- | | |
|--|---|
| <input type="checkbox"/> greater than 12 hours | <input type="checkbox"/> caesarean |
| <input type="checkbox"/> complications | <input type="checkbox"/> hospital |
| <input type="checkbox"/> fetal monitor | <input type="checkbox"/> home birth |
| <input type="checkbox"/> medications | <input type="checkbox"/> premature delivery |
| <input type="checkbox"/> epidural | <input type="checkbox"/> forceps |
| <input type="checkbox"/> vacuum extraction | <input type="checkbox"/> other |
-

Vital Statistics...

The duration of the pregnancy was _____ weeks.

The APGAR score at birth was _____.

The APGAR score at five minutes was _____.

The length at birth was _____ inches.

The birth weight was _____ lbs., _____ oz.

Baby, at birth...

- | | |
|---|---------------------------------------|
| <input type="checkbox"/> difficulty with breathing | <input type="checkbox"/> medication |
| <input type="checkbox"/> abnormal color of skin (blue/jaundice) | <input type="checkbox"/> vitamin K |
| <input type="checkbox"/> inconsolable crying | <input type="checkbox"/> erythromycin |
| <input type="checkbox"/> nursing problem | <input type="checkbox"/> circumcision |
| <input type="checkbox"/> abnormal sleeping pattern | <input type="checkbox"/> other: |
| <input type="checkbox"/> choking | |
-

Nutrition... Check any of the following that the patient has received.

- | | |
|---|---|
| <input type="checkbox"/> breast milk. How long? _____ | <input type="checkbox"/> sweets |
| <input type="checkbox"/> commercial formula | <input type="checkbox"/> juice: fruit/vegetable |
| <input type="checkbox"/> cow's milk | <input type="checkbox"/> solid foods |
| <input type="checkbox"/> goat's milk | <input type="checkbox"/> vitamins |
| <input type="checkbox"/> other milk (i.e. rice, soy, etc) | <input type="checkbox"/> medications |
| <input type="checkbox"/> other: | |

Illnesses... Please list any illnesses.

Family Physician/Pediatrician...

Name: _____

Clinic Name/Location: _____

Date of last exam & reason for visit: _____

General System Review...

- yes / no Has your child ever been unconscious or had a convulsion?
- yes / no Problems with the eyes, including vision?
- yes / no Has your child ever turned blue?
- yes / no Does your child have a problem tolerating exercise?
- yes / no Any recurring problem with vomiting, diarrhea, constipation or stomach pain?
- yes / no Do the stools look or smell abnormal?
- yes / no Any unusual problem passing urine (pain, frequency, blood, smell)?
- yes / no Does your child complain of any extremity (limb) pain or back pain?
- yes / no Do you notice a limb or unusual gait (walking) pattern?
- yes / no Any allergies, eczema, hay fever, asthma or drug reactions?
- yes / no Has your child taken any antibiotics? If yes, how many times? _____
- yes / no Other problems:

Vaccinations... *Please list any vaccinations the patient has received along with the date and any reactions observed.*

Note foreign travel:

Current medication(s)... *List all medications that the patient is currently taking. Also note the reason they were prescribed the medication.*

CONSENT FOR TREATMENT OF A MINOR CHILD

I hereby authorize the doctors at Tenold Chiropractic Health Clinic and whomever they designate as their assistant to administer chiropractic care as they deem necessary to my son / daughter (circle one).

Name of Child: _____

Dated at Eau Claire, WI on: _____

Parent or Legal Guardian signature: _____

Witness: _____

I authorize the release of any medical or other information necessary to process this claim. I understand and agree that any amount authorized to be paid directly to Tenold Chiropractic will be credited to my account upon receipt. I clearly understand that if I suspend or terminated my care and treatment, any fee for professional services rendered me will be immediately due and payable. I further understand that in the event that my responsible party, insurance co., etc. does not cover the full amount, I will pay the balance of my account in full.

I understand that I am accepted as a patient of Tenold Chiropractic. I am authorizing them to proceed with any further treatment that may be necessary. Furthermore, any risks involving chiropractic treatment will be explained to me upon request.

Parent/Guardian authorizing care: _____ Date _____